2023 BlueCross BlueShield of South Carolina Prescription Drug Plans

Jan. 1, 2023 – Dec. 31, 2023

888-645-6025 | TTY 711

Seven Days a Week, 8 A.M. to 8 P.M.
(October 1 to March 31)

Monday - Friday, 8 A.M. to 8 P.M.
(All Other Times)

BlueCross RX PLUS℠(PDP)
BlueCross RX VALUE℠(PDP)
BlueCross RX ESSENTIAL℠(PDP)

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2023 Summary of Benefits
BlueCross Rx Essential (PDP), BlueCross Rx Value (PDP) and BlueCross Rx Plus (PDP)

January 1, 2023 – December 31, 2023

This booklet gives you a summary of what we cover and what you pay. The information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and copayments/coinsurance may change on January 1 of each year. To get a complete list of services we cover, call us and ask for the *Evidence of Coverage.*

You have choices about how to get your Medicare prescription drug benefits

- One choice is to get your prescription drug coverage through a Medicare Prescription Drug Plan, like Rx Essential (PDP), Rx Value (PDP) and Rx Plus (PDP).
- Another choice is to get your prescription drug coverage through a Medicare Advantage Plan (like an HMO or PPO) or another Medicare health plan that offers Medicare prescription drug coverage. You get all of your Part A and Part B coverage, and prescription drug coverage (Part D), through these plans.

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Rx Essential (PDP)**, **Rx Value (PDP)** and **Rx Plus (PDP)** cover and what you pay.

- If you want to compare our plans with other Medicare drug plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your *2023 Medicare & You* handbook. View it online at www.medicare.gov, or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About Rx Essential (PDP), Rx Value (PDP) and Rx Plus (PDP)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Prescription Drug Benefits

This document is available in other formats, such as Braille, large print or audio.

This document may be available in a non-English language. For additional information, call us at 1-800-930-2836 (TTY users call 711).

THINGS TO KNOW ABOUT RX ESSENTIAL (PDP), RX VALUE (PDP) AND RX PLUS (PDP)

Hours of Operation

- From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. Eastern time.
- All other times, you can call us Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

Rx Essential (PDP), Rx Value (PDP) and Rx Plus (PDP) Phone Numbers and Website

- If you are a member of one of these plans, call toll-free 1-888-645-6025 (TTY users call 711).
- If you are not a member of this plan, call toll-free 1-800-930-2836 (TTY users call 711). (Calls to this number are answered by a licensed insurance agent.)
- Our website: www.scbluesmedadvantage.com

Who can join?

To join **Rx Essential (PDP)**, **Rx Value (PDP)** or **Rx Plus (PDP)**, you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, and live in our service area. Our service area includes the following: South Carolina.

Which drugs are covered?

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website (www.scbluesmedadvantage.com) or call Customer Service, and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plans group each medication into one of five "tiers." You will need to use your formulary to locate the tier your drug is in to determine how much it will cost. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document, we discuss the benefit stages that occur (after you meet your deductible – Rx Essential (PDP) and Rx Value (PDP) only): Initial Coverage, Coverage Gap and Catastrophic Coverage.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Which pharmacies can I use?

We have a network of pharmacies. You must generally use these pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our *Pharmacy Directory* at our website (www.scbluesmedadvantage.com). Or call Customer Service, and we will send you a copy of the directory.

Summary of Benefits

January 1, 2023 – December 31, 2023

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

Premium and Deductible Details	Rx Essential (PDP)	Rx Value (PDP)	Rx Plus (PDP)
How much is the monthly premium?	$29.80 per month. You must continue to pay your Medicare Part B premium.	$118.60 per month. You must continue to pay your Medicare Part B premium.	$201.10 per month. You must continue to pay your Medicare Part B premium.
How much is the deductible?	$505 per year for Part D prescription drugs, except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.	$450 per year for Part D prescription drugs, except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.	$0. This plan does not have a deductible.

PRESCRIPTION DRUG BENEFITS

The following section includes information about what we cover and what you pay during the four "drug payment stages" of our plan's benefits. The stages are Yearly Deductible (Rx Essential (PDP) and Rx Value (PDP) only), Initial Coverage, Coverage Gap and Catastrophic Coverage. Your cost-sharing may change as you enter another stage of the Part D benefit. For more details, call us (the number is on the cover of this booklet) or see your *Evidence of Coverage*. The *Evidence of Coverage* is also available on our website.

Initial Coverage	**Rx Essential (PDP)**	**Rx Value (PDP)**	**Rx Plus (PDP)**
What You Pay	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach **$4,660**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies.	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach **$4,660**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies.	You pay the following until your total yearly drug costs reach **$4,660**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies.

How much you pay for your prescription will depend in part on which cost-sharing tier your drug is in.

Tier Number	**Tier Label**	**General Description**
Tier 1	Preferred Generic	The lowest tier and includes preferred generic drugs.
Tier 2	Generic	Includes generic drugs.
Tier 3	Preferred Brand	Includes preferred brand drugs and non-preferred generic drugs.
Tier 4	Non-Preferred Drug	Includes non-preferred brand drugs and non-preferred generic drugs.
Tier 5	Specialty Tier	The highest tier. It contains very high-cost brand and generic drugs that may require special handling and/or monitoring.

Your costs will also differ relative to the pharmacy's status as preferred or standard retail, mail-order, Long-Term Care (LTC), or Home Infusion, and whether you receive a one-month (30-day), two-month (60-day), or three-month (90-day) supply.

Standard Retail Cost-Sharing

Tier	**Rx Essential (PDP)**			**Rx Value (PDP)**			**Rx Plus (PDP)**		
Each plan has 5 cost-sharing tiers	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$15 copay	$30 copay	$45 copay	$10 copay	$20 copay	$30 copay	$5 copay	$10 copay	$15 copay
Tier 2 (Generic)	$20 copay	$40 copay	$60 copay	$20 copay	$40 copay	$60 copay	$8 copay	$16 copay	$24 copay

Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay	$27 copay	$54 copay	$81 copay
Select Insulins	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay
Tier 4 (Non-Preferred Drug)	50% of the cost	50% of the cost	50% of the cost	50% of the cost	50% of the cost	50% of the cost	45% of the cost	45% of the cost	45% of the cost
Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	33% of the cost	33% of the cost	33% of the cost

Preferred Retail Cost-Sharing

Tier	**Rx Essential (PDP)**			**Rx Value (PDP)**			**Rx Plus (PDP)**		
Each plan has 5 cost-sharing tiers	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay	$7 copay	$14 copay	$21 copay	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$5 copay	$10 copay	$15 copay	$15 copay	$30 copay	$45 copay	$3 copay	$6 copay	$9 copay
Tier 3 (Preferred Brand)	$40 copay	$80 copay	$120 copay	$40 copay	$80 copay	$120 copay	$20 copay	$40 copay	$60 copay
Select Insulins	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay
Tier 4 (Non-Preferred Drug)	50% of the cost	50% of the cost	50% of the cost	45% of the cost	45% of the cost	45% of the cost	40% of the cost	40% of the cost	40% of the cost
Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	33% of the cost	33% of the cost	33% of the cost

Standard Mail-Order Cost-Sharing

Tier	**Rx Essential (PDP)**			**Rx Value (PDP)**			**Rx Plus (PDP)**		
Each plan has 5 cost-sharing tiers	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay	$7 copay	$14 copay	$17.50 copay	$0 copay	$0 copay	$0 copay

Tier 2 (Generic)	$5 copay	$10 copay	$12.50 copay	$15 copay	$30 copay	$37.50 copay	$3 copay	$6 copay	$7.50 copay
Tier 3 (Preferred Brand)	$40 copay	$80 copay	$100 copay	$40 copay	$80 copay	$100 copay	$20 copay	$40 copay	$50 copay
Select Insulin	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay
Tier 4 (Non-Preferred Drug)	50% of the cost	50% of the cost	50% of the cost	45% of the cost	45% of the cost	45% of the cost	40% of the cost	40% of the cost	40% of the cost
Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	33% of the cost	33% of the cost	33% of the cost

Plan	**Rx Essential (PDP) and Rx Value (PDP)**	**Rx Plus (PDP)**
Long-Term Care, Out-of-Network and other Limitations	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy in situations where you are not able to use a network pharmacy, but you may pay more than you pay at an in-network pharmacy. For more information on when your drugs can be covered at an out-of-network pharmacy, call us or see your *Evidence of Coverage*. If you go to an out-of-network pharmacy, you may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged. Some drugs have limitations. The limitations are quantity limits, prior authorization, and step therapy.	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy in situations where you are not able to use a network pharmacy, but you may pay more than you pay at an in-network pharmacy. For more information on when your drugs can be covered at an out-of-network pharmacy, call us or see your *Evidence of Coverage*. If you go to an out-of-network pharmacy, you may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged. Some drugs have limitations. The limitations are quantity limits, prior authorization, and step therapy.
Plan	**Rx Essential (PDP) and Rx Value (PDP)**	**Rx Plus (PDP)**
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means there is a temporary change in what you will pay for your drugs. The Coverage Gap begins after the total yearly drug cost (including what our	Most Medicare drug plans have a Coverage Gap (also called the "donut hole"). This means there is a temporary change in what you will pay for your drugs. The Coverage Gap begins after the total yearly drug cost (including what our

	plan has paid and what you have paid) reaches $4,660. After you enter the Coverage Gap, you pay 25% of the cost for covered brand name drugs and 25% of the cost for covered generic drugs until your costs total $7,400, which is the end of the Coverage Gap. Not everyone will enter the Coverage Gap.	plan has paid and what you have paid) reaches $4,660. After you enter the Coverage Gap, you pay 25% of the cost for covered generic drugs until your costs total $7,400, which is the end of the Coverage Gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

Coverage Gap Standard Retail Cost-Sharing

Tier	**Rx Essential (PDP) and Rx Value (PDP)**			**Rx Plus (PDP)**			
Covered Drugs	**One-month supply**	**Two-month supply**	**Three-month supply**	**Covered Drugs**	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	You pay 25% of the cost	You pay 25% of the cost	You pay 25% of the cost	Tier 1 (Preferred Generic)	$5 copay	$10 copay	$15 copay
Tier 2 (Generic)	You pay 25% of the cost	You pay 25% of the cost	You pay 25% of the cost	Tier 2 (Generic)	$8 copay	$16 copay	$24 copay
Select Insulins	$35 copay	$70 copay	$105 copay	Select Insulins	$35 copay	$70 copay	$105 copay

Coverage Gap Preferred Retail Cost-Sharing

Tier	**Rx Essential (PDP) and Rx Value (PDP)**			**Rx Plus (PDP)**			
Covered Drugs	**One-month supply**	**Two-month supply**	**Three-month supply**	**Covered Drugs**	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	You pay 25% of the cost	You pay 25% of the cost	You pay 25% of the cost	Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	You pay 25% of the cost	You pay 25% of the cost	You pay 25% of the cost	Tier 2 (Generic)	$3 copay	$6 copay	$9 copay
Select Insulins	$35 copay	$70 copay	$105 copay	Select Insulins	$35 copay	$70 copay	$105 copay

Coverage Gap Standard Mail-Order Cost-Sharing

Tier	Rx Essential (PDP) and Rx Value (PDP)			Rx Plus (PDP)			
Covered Drugs	**One-month supply**	**Two-month supply**	**Three-month supply**	**Covered Drugs**	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	You pay 25% of the cost	You pay 25% of the cost	You pay 25% of the cost	Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	You pay 25% of the cost	You pay 25% of the cost	You pay 25% of the cost	Tier 2 (Generic)	$3 copay	$6 copay	$7.50 copay
Select Insulins	$35 copay	$70 copay	$105 copay	Select Insulins	$35 copay	$70 copay	$105 copay

Catastrophic Coverage:

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of:

- **5%** of the cost, or
- **$4.15** copay for generic (including brand drugs treated as generic) and **$10.35** copay for all other drugs.

You will pay a maximum of $35 for a 1-month supply of covered insulin during the deductible, initial coverage, coverage gap or "donut hole" and catastrophic stages of your benefit. Your cost maybe less if you receive “Extra Help” from Medicare.

The formulary and pharmacy network may change at any time. You will receive notice when necessary.

BlueCross BlueShield of South Carolina is a Medicare Advantage PDP organization with a Medicare contract. Enrollment in BlueCross BlueShield of South Carolina depends on contract renewal.

Getting Started

The following forms are needed to enroll in a BlueCross Prescription Drug Plan

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

PDP Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a sales representative at 1-800-930-2836 (TTY users call 711)

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.scbluesmedadvantage.com or call 1-888-645-6025 (TTY users call 711) to view a copy of the EOC.

- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2023.

BlueCross BlueShield of South Carolina is a Medicare Advantage PDP organization with a Medicare contract. Enrollment in BlueCross BlueShield of South Carolina depends on contract renewal.

OMB No. 0938-1378
Expires:7/31/2024

2023 BlueCross Rx Essential℠/Rx Value℠/Rx Plus℠ (PDP) Individual Enrollment Request Form

Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Prescription Drug Plan, you must also have either, or both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 - December 7 each year (for coverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

If you want to join a plan during fall open enrollment (October 15 - December 7), theplan must get your completed form by December 7.

- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account, credit/debit card or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
BlueCross Rx
P.O Box 100191
Columbia, SC 29202

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call BlueCross Rx at 1-888-645-6025. TTY users can call 711.

Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a BlueCross Rx al 1-888-645-4227/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanentresidence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

OMB No. 0938-1378
Expires:7/31/2024

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

_____ BlueCross Rx Essential - $29.80 per month
_____ BlueCross Rx Value - $118.60 per month
_____ BlueCross Rx Plus - $201.10 per month

FIRST name:_____

LAST name:_____ (Optional) Middle Initial:_____

Birth date: (MM/DD/YYYY) (____/____/____) Sex:____Male____Female

Phone number: (____)_____- __ ____ _

Permanent Residence Street address
(Don't enter a PO Box):_____

City:_____ State:_____ ZIP Code:_____

Mailing address, if different from your permanent address (PO Box allowed):

Street address:_____

City:_____ State:_____ ZIP Code:_____

Emergency Contact: _____

Phone Number: (____)_____- _____ Relationship to You: _____

E-mail Address: (optional)

_____

Your Medicare information:

Please take out your red, white and blue Medicare card to complete this section.

□ Fill out this information as it appears on your Medicare card

– OR –

□ Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare Card):

_____

Medicare Number: _____

Is Entitled To: Effective Date (MM/DD/YYYY):

HOSPITAL (Part A) _____/_____/_____
MEDICAL (Part B) _____/_____/_____

You must have Medicare Part A and/or Part B to join a Medicare Prescription Drug Plan.

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to BlueCross Rx?

_____ Yes _____ No

Name of other coverage: Member number for this coverage: Group number for this coverage:

_____ _____ _____

IMPORTANT: Read and sign below:

• I must keep both Hospital (Part A) and/or Medical (Part B) to stay in BlueCross Rx.
• By joining this Medicare Prescription Drug Plan, I acknowledge that BlueCross Rx will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
• Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
• The information on this enrollment form is correct to the best of my knowledge. I understand that if Iintentionally provide false information on this form, I will be disenrolled from the plan.
• I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
• I understand that my signature (or the signature of the person legally authorized to act on my behalf) onthis application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
1) This person is authorized under State law to complete this enrollment, and
2) Documentation of this authority is available upon request by Medicare.

Signature:_____ **Today's date:**_____

If you're the authorized representative, sign above and fill out these fields:

Name: _____

Address: _____

_____

Phone number: (____)_____-_____Relationship to enrollee: _____

Agent Use Only:

Plan ID#: _____

Effective Date of Coverage: _____

ICEP/IEP:_____AEP:_____SEP (type): _____

BlueCross BlueShield of SC MAPD Agent ID: _____

Agent Name: _____

Date: _____

Agents must submit a signed enrollment form within 24 hours of receipt.

Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

___No, not of Hispanic, Latino/a, or Spanish origin
___Yes, Mexican, Mexican American, Chicano/a
___Yes, Puerto Rican
___Yes, Cuban
___Yes, another Hispanic, Latino/a, or Spanish origin
___**I choose not to answer**.

What's your race? Select all that apply.

___American Indian or Alaska Native
___Asian Indian
___Black or African American
___Chinese
___Filipino
___Guamanian or Chamorro
___Japanese
___Korean
___Native Hawaiian
___Other Asian
___Other Pacific Islander
___Samoan
___Vietnamese
___White
___**I choose not to answer.**

Select one if you want us to send you information in a language other than English.

Spanish_____ Other ____

Select one if you want us to send you information in an accessible format.

___ Braille ___ Large Print ___ Audio CD

Please contact BlueCross at 1-888-645-6025 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., Eastern Time, Monday - Friday. Our automated phone system handles calls received after 8 p.m. and on Saturdays, Sundays and holidays. From October 1, through March 31, we are available 8 a.m. to 8 p.m., Eastern Time, seven days a week.

Do you work?____Yes_____No Does your spouse work? ___Yes ___No

List your Primary Care Physician (PCP), clinic, or health center:

_____

I want to get the following materials via email. Select one or more.

___ Evidence of Coverage ___ Pharmacy Directories ___ Formulary

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT) or credit card each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay BlueCross the Part D-IRMAA.

Please select a premium payment option:

☐ Get a bill.

☐ Electronic funds transfer (EFT) from your checking account each month. Please enclose a VOIDED check or provide the following:

Account holder name:_____

Bank routing number: __ __ ____ ____ ____ _

Bank account number: __ __ ____ ____ ____ __ __ __ __ __ ____ ____ _

☐ Credit Card. Please provide the following information:

Type of Card: _____

Name of Account holder as it appears on card: _____

Account number: __ ____ __ ____ ____ _____ __ ____ ____ _

Expiration Date (MM/YYYY):____/ _____ _

Automatic deduction from your monthly Social Security/Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

OMB No. 0938-1378
Expires:7/31/2024

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan, or I recently moved and this plan is anew option for me. I moved on (insert date)_____.

☐ I recently was released from incarceration. I was released on (insert date) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date)_____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.

☐ I recently left a PACE program on (insert date)_____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date)_____.

☐ I am leaving employer or union coverage on (insert date)_____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date)_____.

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact BlueCross at 1-888-645-6025, TTY users should call 711. Our office hours are 8 a.m. to 8 p.m., Eastern Time, Monday - Friday. Our automated phone system handles calls received after 8 p.m. and on Saturdays, Sundays and holidays. From October 1, through March 31, we are available 8 a.m. to 8 p.m., Eastern Time, seven days a week.

South Carolina | **Scope of Sales Appointment Confirmation Form**

Medicare Beneficiary, please initial below beside the type of product(s) you want the agent to discuss.

☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**
Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicarer certain Medicare plans.
☐ **Medicare Advantage Plans (Part C/MA)**
Medicare Health Maintenance Organization (HMO) —A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
Medicare Preferred Provider Organization (PPO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above.

Signing this form does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment status, or automatically enroll you in a Medicare plan or the plan(s) discussed.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: _____

Signature Date: _____

If you are the authorized representative, please sign above and print below:

Representative's Name: _____

Your Relationship to the Beneficiary: _____

South Carolina | **Scope of Sales Appointment Confirmation Form**

The Centers for Medicare & Medicaid Services requires agents to document the scope of a marketing appointment prior to any sales meeting to ensure you understand what will be discussed.

To be completed by Agent:

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone (Optional):
Initial Method of Contact (Indicate here if beneficiary was a walk-in):	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	
Date Appointment Completed:	

Scope of Appointment documentation is subject to CMS record-retention requirements

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at [1-888-645-6025]. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-396-0183. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-844-396-0188。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-844-725-1516。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-389-4839. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-396-0190. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-389-4838 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-396-0191. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-396-0187 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-389-4840. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-844-396-0189 سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें [1-844-725-1519] पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-396-0184. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-396-0182. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-398-6232. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-396-0186. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-844-396-0185 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association